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Original Communications.

WATERMELON vs. DIARRHŒA.

By CHARLES E. BUCKINGHAM, M.D., BOSTON.

THE article in the JOURNAL of August 19 is of value, and it is to be hoped that other gentlemen will follow Dr. Webber's suggestion. I should like to incorporate my experience with his and theirs.

Mine shows first, that many of the so-called diarrhœa medicines aggravate the disease, and make of the diarrhœa a dysentery. The mixtures of opium, camphor, capsicum and rhubarb will often do this, more especially if the intestines be not first cleared out. Even if they be, dysentery not infrequently follows the use of these mixtures.

Secondly, the diarrhœa often becomes a choleraic disease, attended with excessive vomiting and with cramp, even if finally checked.

Thirdly, and this is no new observation, the neutral salts in small doses, such as sulphate of magnesia, sulphate of soda, and the tartrate of potash and soda, after clearing out the canal, will be followed by comparative freedom from discharges. This is the case in a marked degree in dysentery, and oftentimes is followed by recovery without the use of opium.

Fourthly, in combination with small doses of morphia, or without, according as there has or has not been pain, I have found no medicine control dysentery with so much satisfaction as bitartrate of potash. Mixed with some essential oil, sugar and water, it is a most grateful drink, and comes the nearest to—

Fifthly, peaches. Our prejudices and tastes probably affect our prescriptions. Perfectly ripe peaches, in no degree decayed, make the best dose for ordinary diarrhœa and dysentery; sometimes with, sometimes without morphia, according to the presence or absence of pain. I prescribed a quart for a patient to-day.

Why not watermelon? Why not pears? There is a prejudice in our community

against both. Is not the reason this, that the former is often eaten unripe, the latter over ripe and even rotten?

Sixthly, there are other fruits of which we swallow the seeds, such as grapes, blackberries, whortleberries, blueberries and raspberries, all of which some of us have found useful in diarrhœa. We swallow the seeds of all of these, and the question might well be raised, whether the tannin in the seeds may not have a part in the play. With the grape, it sometimes seems as though the seed and the skin, if swallowed, might be the cause of mischief. I have notes of an apparently marked case of this effect of the seeds, in which they were retained in the intestine for weeks.

I have now under observation a patient, who for months had diarrhœa, but who has had only one defecation daily, since blueberries came into the market this season. That one has been obtained by a daily dose of Seidlitz powder for three weeks past.

"Watermelon vs. diarrhœa" opens up a number of questions well worth examining, and if some of the gentlemen who are to write dissertations for their degrees, would spend a part of their time in investigating them, they might do themselves a credit, and the world a favor.

Many medical men prescribe what is according to rule, and solely because some one has given the rule. Chalk mixture, for instance, is said to be useful in diarrhœa. How many men question the cause of the diarrhœa, when they are about to prescribe chalk mixture? Why do they prescribe it? One gentleman answers, "because it is lime, and lime is an antacid." Very well, if there be what is called acidity of the stomach, his prescription is perhaps correct. Another answers—"because lime is an astringent, and an astringent is needed to constipate." But I find that he seldom prescribes chalk mixture without the addition of another astringent, like catechu or kino; and, as if to upset his own theory, he advises his patient going west to beware of drinking water in certain localities, because it contains lime and will surely give him diarrhœa.

[WHOLE No. 2166.]

I hope Dr. Webber will go on with "Watermelon vs. Diarrhoea." Some one will read his article and experiment.

A REMARKABLE CASE OF STRANGULATED OBLIQUE INGUINAL HERNIA SIMULATING HYDROCELE OF THE CORD.

By W. H. TRIPLETT, M.D., of Woodstock, Va.

JULY 6, 1869, was called to J. J., colored, at 8, A.M. Was vomiting, and complained of some abdominal pains; said he had suffered through the whole night; had not indulged in any dissipation the day before; had eaten a light supper and had retired about 11, P.M., feeling very badly in his bowels; "he was ruptured on the right side, and this morning he could not get it all back." The vomited matter was stercoraceous, and I at once made inquiry if he was ruptured, and elicited the above facts. Upon examination, I found an oblique inguinal hernia, in the shape of a soft tumor, lying under the edge and extending below the external abdominal ring, about as large as a hen's egg, which I readily returned to the abdominal cavity, and the index finger impinging against the external ring, it felt patulous and empty, so that I believed the hernia had been entirely reduced; yet upon further examination, I discovered a scrotal tumor larger and harder than a healthy testis, together with the testis of that side, but lying above the latter organ, and having no direct connection with it; it was as large as an ordinary lemon.

It was exceedingly hard, and situate about $1\frac{1}{2}$ inches from the external ring; several fingers could be introduced between it and the ring, and the spermatic cord to all appearances seemed the only connecting medium between it and the abdominal viscera. The cord was distinctly felt, and did not appear to be much augmented in bulk; it seemed to spring from the cord.

It was sensitive to gentle manipulation. When pushed upward against the abdominal ring, it would, if not prevented, at once return to its former position, maintaining its distance and preserving its isolated condition and obscure character.

Was it a hernia? an encysted hydrocele? or a fibrous tumor?

The patient said "the lump had come during the night." This statement was incompatible with the last two suppositions, and taken in connection with the gastric disturbance and intestinal pains, would seem to make the former stand to the lat-

ter, as cause and effect; if this be the case, then it must be a hernia. If the latter, the issue was of so grave a character that no time could be lost on anodynes and opiates, but recourse must be had at once to chloroform and the taxis.

These were made use of, but it was found impossible to displace the scrotal tumor, or throw any new light upon its nature.

A careful dissection was now made by means of the scalpel and grooved director down upon the contents of the tumor. Several ligatures had to be used on account of free hæmorrhage from two rather large arteries for this region; finally, the inner or true tunic was reached, but it was so very tight from distention, that it was impossible to seize it with the nibs of the forceps, and a small puncture was made in it, through which issued a jet of serum. The grooved director was now introduced, and the capsule, or sac, as the case might be, freely opened up. A knuckle of intestine of about two (2) inches in length, including the calibre of the vessel, was discovered in the cavity, darkly discolored and ecchymosed. Careful taxis directly applied to the gut could not reduce it. It was closely embraced by the stricture, which was composed of thickened and corrugated folds of the hernial sac, imprisoned by a ring of almost cartilaginous hardness. After its division, the bowel was manipulated through the narrow strait, and, gliding over the external abdominal ring, readily dropped back into the abdominal cavity. Introducing the index finger and hooking up the site of the stricture, it felt between the thumb and finger to be of uniform thickness, and to extend all round the sac, which was universally adherent. He had been ruptured for ten years.

The parts were now united by several points of interrupted suture, and a compress saturated in a solution of carbolic acid in boiled linseed oil, in proportion of one part of the former to ten of the latter, was applied over the wound.

When he recovered from the anesthesia, all the gastric distress and the anguish of strictured bowel were gone, and he expressed himself as feeling more comfortable than he had ever expected to be again.

Two grains of opium were now ordered to be given every two hours until sound sleep should be induced, to ward off inflammation and to act as a splint to the bruised bowel.

Aug. 7th.—Restored well, and has no pain this morning or abdominal tenderness.

8th.—Is pretty much in the same condi-

tion as yesterday; has no pain and is doing well.

9th.—Passed a large stool of clotted blood and fecal matter, decomposed and of foul odor, last night. Had several stools of the same character through the day.

10th.—Is bright and cheerful this morning; says he passed more blood during the night.

From this time on he rapidly improved, and now the patient is sitting up, fully convalescent.

August 17, 1869.

TREATMENT OF SYPHILIS BY SUBCUTANEOUS INJECTIONS.

(Concluded from page 51.)

It only now remains for us to give the results of this treatment in the General Hospital at Vienna, to complete our review of all that has thus far been published in Germany upon this subject.

Dr. G. Lewin, of Berlin, having published 500 cases of syphilis cured by hypodermic injections of corrosive sublimate, the directors of the syph. department of the General Hospital in Vienna considered it their duty to test the value of this method. Dr. J. Grünfeld was entrusted with the execution of their desire, and endeavored, in justice to Dr. Lewin, to follow precisely his *modus operandi*. He chose well-marked cases of constitutional infection characterized by an exanthema, and made use of the same solution, viz., 4 gr. of sublimate to 1 ounce of distilled water, and in accordance with the various conditions of the patients, employed for each inj. 8 to 24 drops, i. e., $\frac{1}{16}$ to $\frac{1}{4}$ grain of sublimate.

He reports* the invariable presence of a more or less severe sensation of burning during and immediately after the injection, varying with the individual sensibility, the nature of the skin, the place chosen for injection, the size of point of instrument, the amount and concentration of the solution and the dexterity of the operator. This sensation is soon lost, and may or may not be followed by smarting which generally, though not always, is in proportion to the extent of local reaction. In two cases only out of twenty-five thus far treated was this smarting severe and not to be relieved by treatment.

The objective symptoms were various.

* Bericht ueber hypodermatische Sublimat-Injektionen gegen konstitutionelle Syphilis, von Dr. J. Grünfeld, Sekundararzt der Klinik für Syphilis des Prof. v. Sigismund in Wien.

Generally, immediately after the injection, a circumferential hyperæmia showed itself, followed by central induration, but no other sign of inflammation. The hyperæmia vanished in 3-4 hours; the induration lasted, however, for an indefinite period. In several cases there appeared within ten minutes, together with the induration in the centre of the hyperæmic spot, one or more pale vesicles. This occurred chiefly when the injection was too superficial or the syringe was emptied too rapidly. The vesicles, however, shrank and disappeared within six hours, leaving a small brown spot with a yellowish margin. These also disappeared in a few days, leaving only the induration. When the vesicle did not entirely shrink up, one could see in a few hours a diffused brownish-red spot about half an inch in diameter, deeper colored towards the centre, which, composed of the half-shrunk vesicle, was about the size of a lentil, dirty white, lying in folds and easily to be moved upon or torn from the tissues beneath. This condition lasted several days, and then the centre dried and was thrown off. After large doses, $\frac{1}{4}$ gr., especially on an ill-adapted location, there remained after involution of the vesicle a dirty spot, easily to be pushed from its place, about the size of a nickel cent and surrounded by marked symptoms of inflammation. Here the subjective appearances were also more strongly marked. The spot dried up in two or three days, and the pain ceased. The brownish-red color, nevertheless, often remained for six weeks or more. After 600 injections, Dr. Grünfeld has seen, as yet, no case of formation of abscess. Lewin states that though these occurred during the earlier period of his treatments by injection, yet amongst his last 100 patients thus treated he has met with but two or three cases of abscess, and these of but slight importance.

The local effects of the injection are due to the corrosive action of the sublimate. This drug when swallowed unites with the albumen of the contents of the stomach, or if it finds therein too little, with its walls, forming albuminate of sublimate and producing a scab. So in subcutaneous injection. The sublimate unites with the albumen of the intercellular fluids and tissues. The albuminate of sublimate consists [Mulder] of oxide of mercury and albumen, and is the cause of the induration if the injection is deep, or of the mummifying of the skin if the injection is superficial. The brown, brownish-red or black scab is gradually thrown off without laying bare the corium,

and after some weeks a mere stain remains. This applies only, however, to injections of a solution not too concentrated. In 1867 four persons were by accident injected with a solution of sublimate kept for external application, the strength being 3j. of the sublimate to 3j. spir. vini. rectific. Of this 11 gr. was injected, i. e., $1\frac{1}{2}$ gr. of sublimate. The result was in each case a dark strongly-adhering scab, $\frac{1}{2}$ to $\frac{3}{4}$ inch in diameter, surrounded by a deep-red discoloration. This loosened itself partially after some days, and removal of it showed the tissues beneath necrosed, in the form of dirty-white shreds, the border of the wound elevated, and appearances of violent inflammation growing less towards the periphery. The sores were a long time in healing, the formation of pus very moderate.

The universal constitutional effect of the sublimate is independent of the place of injection; the best situations, however, are those where the appearances of reaction are the least, viz., the sides of the breast-region, the hypochondriums, the back towards the sides, and the nates as high as the crista ili. Avoid the neighborhood of lymph glands, the flexor side of the extremities and the legs below the knees, as, especially in the last case, pain and difficulty in movement, even in bed, are the results. Those syphilitic efflorescences which are in the immediate neighborhood of the place of injection are the first to disappear. [Hebra.]

A subsequent injection must never be made within two inches of a previous one, as the skin, even if no longer painful, has acquired a closer connection with the tissues beneath, rendering it impossible to make a proper fold for the insertion of the canula. The actual mechanical and chemical change has deprived the part of vitality for absorbing a second injection, and rendered it more liable to necrotic destruction. Such a second injection was made *experimenti gratia*, and $\frac{1}{10}$ gr. sublimate injected at the periphery of an induration still remaining from an injection made twelve days before. Result intense hyperæmia, mummifying of the skin in a circle of $\frac{3}{4}$ of an inch in diameter, an induration as large as a pigeon's egg, and great pain lasting over four weeks.

The adaptation of the skin for injection depends on its thickness, on its closeness of connection with the subcutaneous tissues, on the amount of fat in the subcutaneous cell tissue, and finally on the age of the patient. The local and general effects are the least when the injection is performed where the skin is most movable and folds

are easiest made. If the skin is thin and the panniculus adiposus moderate in amount, we see often no local effects even after many injections. So with old persons, where the skin is dry, hard, poor in fat and easily to be moved; such patients, if the choice is given them, after a trial of both methods always prefer a treatment by injection to one by innunction.

The best syringe for the purpose is made of hard India rubber, as this is least readily attacked by the corrosive drug. The measurement of its contents should be made in grains rather than in drops. The exact dose administered should always be known. The bore of the syringe should be everywhere the same, and the piston exactly fill it. The canula should have a point like a pen, for if lance-shaped the pain of extraction is greater than that of insertion. This point must be as small and the canula as smooth as possible. Careful cleansing of the canula and occasional sharpening of its point are necessary to preserve them from the action of the sublimate. With care one canula will suffice for one hundred injections. As a rule, one injection per diem is sufficient, though the administration of two seems sometimes to hasten the cure. A fold of the skin is to be raised between the thumb and forefinger of the left hand; the canula should be inserted quickly and through the cutis into the subcutaneous cellular tissue, and then pushed well in. During the injection the point of entrance of the canula should be covered with the left forefinger, and the canula itself gradually withdrawn, so that its point at completion of the injection shall be near the place of its insertion into the skin. On the removal of the canula, the forefinger, before quitting the skin, should press and rub the wound slightly to one side, as this prevents loss of the injection or of any blood. The wound may then be covered with a bit of plaster. With regard to diet, clothing, bathing, &c., this mode of treatment requires no departure from usual habits.*

Nine months later† Dr. Grünfeld makes another report of 60 cases thus treated, comprising nearly all varieties of appearances. Nearly all were cured. Some of these cases went about their work as usual, during the treatment. The dose used was, as a rule, $\frac{1}{4}$ gr. at each injection, though varied somewhat, according to the variety or intensity of the symptoms. The treatment was often interrupted on account of

* Wiener Medizinische Presse, Nos. 17, 20, 24, 28, 1868.

† Ibid., No. 12, Dec. 5th, 1868.

the occurrence of salivation. Here Dr. Grünfeld does not mention the intervals of time between the doses, nor the whole number of injections administered in any case.

To the department for diseases of the skin, under the care of Professor Hebra, are sent cases of cutaneous syphilis, as well as other cases when, as often happens, all the wards specially devoted to this disease are full. Here, also, during the past year, similar experiments were made. Result unfavorable, 45 per cent. of those treated being salivated; and the advantages of this method over that by inunction not being specially manifested, the former has now been discontinued.

The following brief summary of facts noticed I compile from the protocols of the individual cases treated. Number of patients treated, 20. Of these, 16 men, 4 women. These cases included the most various forms, from simple exanthemata to old serpiginous ulcers and gummata. The duration of the disease at the time of entrance varied from four weeks to twelve years. The number of injections administered varied from five to forty-seven. All the cases were discharged "healed." Where several different manifestations of syphilis were present, the first to disappear was generally the roseola. The duration of treatment varied from 14 to 63 days, the cases of speediest recovery being either the very recent, with simple roseola, &c., or the very old, in which the only manifestations were ulcerations; which latter were in addition always cauterized. In 9 cases salivation occurred, 3 of these being women. The earliest appearance of salivation was in a woman with papules and psoriasis palmaris of five months' standing. This occurred on the 5th day, after 5 injections. The latest was in a man with papules, infected twelve years before, who after 38 injections had a new eruption of papules, and after 47 inj., or fifty-eight days, became salivated. In this case inunction had also been used after the second eruption of papules. In two other cases inunction had also been employed from the first. Here salivation set in, in one case after 5 inj. and five days, in the other after 7 inj., eight days. As a rule the injections were discontinued when salivation occurred, and iod. pot. or sublimate baths were substituted. Other modes of treatment employed during the administration of the injections were, invariable caution of ulcers, and in a few cases the exhibition of decoctum zittmanni. There was no new formation of abscesses, and only two

cases of relapse, one the case of papular syphilis already mentioned, the other a second eruption of pustules upon a man after 30 days and 19 injections.*

Hospital Reports.

MASSACHUSETTS CHARITABLE EYE AND EAR INFIRMARY.

Some Cases in the Service of Dr. B. JOY JEFFRIES.

Sudden Blindness from Glaucoma Fulminans cured by Iridectomy; with Remarks.—A woman, æt. 52, had pain in the right eye, coming on suddenly, during the day, Oct. 20th, 1867, and by the next morning her sight in this eye was reduced to the simple perception of light. Five days afterwards she applied at the Infirmary, with all the typical signs of glaucoma and serous infiltration of the cornea. Iridectomy was proposed to relieve the pain, but with no great hope of restoring vision. It was not allowed till the next day morning, when I did it upwards. This caused cessation of the pain, and at 4, P.M., the patient was quiet, the other (left) eye remaining perfect. About 11, P.M., pain commenced in this eye, and the following morning, when seen by me, the patient was *totally blind with glaucoma fulminans*. I of course did iridectomy upwards at once, and also paracentesis of the right cornea, as the iridectomy had not seemed to have reduced the irritation entirely. In less than a month, Nov. 16th, the patient read Jäger 6 with $+\frac{1}{2}$, and vision for distance was $-\frac{1}{2}$ with the left, the second eye attacked. The right eye was almost quiet, but has only perception of light. The patient was allowed to go home Nov. 18th. Shortly afterwards, Dec. 2d, she returned, with pain in the eye first attacked, the right, and iridochoroiditis. My colleague, Dr. Hay, under whose care she then came, extracted downwards the cataractous lens, with relief to the pain, and the patient was discharged Dec. 21st, 1867, vision remaining as above recorded. Within a fortnight, i. e. sixteen months after the first attack, the patient has presented herself to Dr. Hay, to be fitted for glasses for the left eye, which she now can use as before; and with the other, the first attacked, and from which the lens was extracted, she counts fingers with $+\frac{1}{2}$. An additional iridectomy

* Jahresbericht der Abtheilung für Hautkrankheiten des Prof. Hebra in Wien.

for artificial pupil, he thinks, may give her considerable more vision in this eye.

Before the days of iridectomy this patient would have as certainly been blind in both eyes as she was saved one and perhaps the other by it. Of course, iridectomy should have been done on the other apparently perfectly sound eye at the same time. Unfortunately, we are too far from the period when physicians, much less patients, will realize this. The whole case was perfectly typical. In five days the disease had so damaged the right eye that iridectomy alone did not check the progressive trouble, which extraction of the already cataractous lens did. No doubt iridectomy, timely performed on the right eye, would have had the same success as in the left. This operation, which we must do, seems to hasten glaucoma in the other eye, and a patient should never be allowed to go out of immediate reach. In view of such a case as this, by no means so very uncommon, it would almost seem that the general surgeon or physician should be taught to operate for acute glaucoma, as every hour is one of increasing disease and lessening chances of perfect restoration of sight by surgical interference. At any rate he should know that, when a patient has become rapidly blind, has fearful pain, and the eye looks inflamed and is as hard as a marble, there is *something wrong*, and this something is glaucoma, for which iridectomy or its equivalent is the only cure, and the most brilliant discovery in ophthalmic surgery. I will not stop to discuss the relative merits of iridectomy and puncture of the globe as performed by Mr. Hancock, or what is in reality done by this latter. *Intraocular pressure* is the essential evil in glaucoma and must be relieved at once—the sooner, the better the chance for restoring sight to the eye. The ophthalmoscopic appearances in the optic nerve and retina are more or less truthfully given in the various textbooks on the eye. No plates as yet surpass those of Jäger and Liebreich. At present these are refinements for the ophthalmic surgeon. A hard, painful globe, dilated and muddy pupil, hazy cornea and rapid diminution of vision are the rough symptoms for the general practitioner to remember as connected with glaucoma, and not to be neglected or treated with *acetate of lead, nitrate of silver, or borax wash*.

The newest points in regard to operation are the suggestions lately made by Stellwag that perhaps the portion of iris need not be removed, the simple opening of the sclerotic and the subsequent presence of

an *elastic cicatrix* being sufficient to permanently reduce the intraocular pressure. He met with success in one case by thus operating; naturally, however, mentions it as to be imitated with caution. I tried it quite recently. The immediate prolapse of the iris, however, as I anticipated, called for its removal as usual. The use of Graefe's narrow cataract knife, instead of the bent, lance-shaped iridectomy one, to make our opening in the sclerotic with, is, I consider, often of advantage when the anterior chamber is much reduced in depth.

Since the introduction of iridectomy there have been many experiments carried out in reference to intraocular pressure, and a great deal of thought expended on it. Prof. Stellwag has lately carefully gone through critically all that has been done, and gives the following as the at present settled formulæ in reference to intraocular pressure:—

1. Intraocular pressure is essentially due to the lateral pressure of the vessels of the circulation within the globe.
2. Under otherwise normal relations of the eye, intraocular pressure is nearly constant, with perhaps individual variations.
3. The stability of the internal pressure is in close causal relation with the invariability of the amount of blood at the time circulating within the eye.
4. Stability in the amount of blood within the globe does not exclude an unequal distribution of it in the internal circulation; it implies overflowing of some parts, corresponding to emptying of others, and the reverse.
5. In this compensating change of fullness the uvea appears to play the principal part, from its being so largely composed of vessels.
6. The stability of the internal pressure and the intraocular amount of blood are both in the same manner referable to the regulating influence which the tense, elastic capsule of the globe exerts on the conditions of the circulation within the eye.

To Memorski is due the credit of having first called attention to these very important relations and their connection.

I would take this opportunity to warn against the use of atropine in anything which looks like glaucoma, especially as this drug is so generally used in ophthalmic practice, and nearly always with benefit. Recent observation and experimentation would seem to contra-indicate atropine as liable to increase intraocular pressure; how, we are yet unable to say.

It is, of course, not needed to dilate the

pupil, as this takes place from the disease itself, being a marked symptom. The accumulated literature of the past years, embodying the results of experiments and clinical observations, has lately been carefully analyzed by Stellwag, who says that the following may be regarded as practical conclusions in reference to the action of mydriatics and myotics, and the nervous relations of the iris.

1st. Mydriatics and myotics, applied as collyria, act principally on the ciliary ganglionic system.

2d. Mydriatics cause it to lose the power of allowing the passage of the nervous streams carried from the central end of the ciliary oculo-motorius branches; it remains, however, capable of receiving direct irritation, and that which comes from the sensitive terminal branches of the fifth, and transmitting this with undiminished force to the motor terminal fibres passing out from it, namely to produce contraction of the sphincter and ciliary muscle, acts, therefore, like complete interruption to conduction through the oculo-motorius trunk. The sympathetic tubes, on the other hand, leave the ganglia when these are affected by mydriatics, with increased irritation, unless the functional connection with the cerebral origin has been severed, since its interruption by cutting the cervical sympathetic weakens the reaction in a marked degree. Slight irritation of the sensitive trigeminal twigs may increase the degree of irritation in the terminal sympathetic branches through means of the ganglia; strong irritation, however, reverses this to paralysis, and deprives the ganglia of the power of conducting nervous streams that were started in the peripheral string or its centre. In the sympathetic and oculo-motorius tubes the functional disturbance of the ganglia from mydriatics is expressed in quite the reverse manner. The sensitive fibres of the trigeminus are not noticeably interfered with in their centripetal conduction.

3d. Myotics, acting through the ganglionic system of the eye, excite the ciliary terminal branches of the third pair, and hinder within their district the effect of the nervous streams which have come from the brain. On the other hand they (myotics) weaken or paralyze by their effect on these ganglia, the sympathetic ciliary nerves coming out from the ganglia, without, however, especially affecting the conduction between the central cerebral origin and the terminal subdivisions. The functions of the ciliary fibres of the fifth are but little if at

all affected by them (myotics).—*Der intra-oculare Druck und die Innervations-verhältnisse der Iris.* Prof. Dr. Karl Stellwag von Carion. Wien, 1868.

Extreme divergent Strabismus, the result of Operation, relieved by bringing forward the Internal Rectus Muscle.—A married woman, æt. 29, has extreme divergent strabismus of the right eye. With effort the inner edge of the cornea can be brought inwards up to the median line. The consequent disfigurement to the patient, otherwise a comely woman, is very great. The patient says it is the result of operation and after-treatment for convergent strabismus, by a surgeon in a neighboring city. April 26, 1868, I dissected a flap of conjunctiva, and found the muscle attached to it, and not to the globe. The muscle was dissected free, and a needle passed through the end of the conjunctival flap and the end of the muscle, and these sewed to the conjunctiva close to the cornea. Then the lowest corner of the flap was sewed to the conjunctiva below the centre of the cornea. The rectus externus tendon was now cut, and no conjunctival stitch taken. The patient had violent vomiting from the ether, and pain during the night, which had gone by the next day. As was feared, the muscle had been so frayed up or cut away by previous operation and treatment, that Dr. Agnew's method could not here be used by me. The muscle attached itself to the globe, and the eye was rendered straight for distance; it can also be readily adducted to bring the outer edge of the cornea to the centre. The stitches were left for six days, when one was found loose, and both were removed. A small piece of the frayed end of the muscle was snipped off. Four days after a small corneal ulcer appeared towards the inner side, where the muscle was attached. Atropine was used, and next day fungous granulations were touched with arg. nit. These sloughed off with some conjunctival irritation, but the pain, which had been troublesome at night, ceased. May 10, 1868, the corneal ulcer is healing, and the patient bears light; atropine continued. Discharged May 19, 1868. Vision in this right eye $\frac{25}{25}$ at 4 ft. Vision of other eye $\frac{3}{20}$ at 20 ft. A convergence of $1\frac{1}{2}$ lines exists, in comparison most satisfactory to the patient. Ulcer nearly healed, motion good. I saw the patient in August again, and heard from her in September. There remained a fading opacity of the cornea where the ulcer had been. Patient could not use the eyes for continuous fine work over an hour. There was probably hypermetropia original.

ly, which caused the convergent squint, the operation for which produced excessive divergent squint, and a consequent reduction of vision in the eye to $\frac{1}{5}$. From the condition of the eyes the refraction had not been determined and corrected with glasses. This remains to be attended to.

June 20, 1869.—The patient writes me thus:—"The sight does not strengthen as I can perceive, but my eyes have an easy homefeeling, very comfortable and pleasant. I can thread a needle without trouble, and sew and read considerable."

A result so satisfactory in a case whose previous history was so unpromising, proves as Prof. Graefe has conclusively shown, that a carefully conducted operation can remedy many of the deformities we meet with, which are occasioned only too often by ignorant or blundering surgery. In fact, it is only recently that confidence has been restored, particularly in Paris, in the ordinary operation for squint. Every squinting eye was formerly operated on by the general surgeon, till finally the number of cases of want of success gradually prevented any from interfering with them.

There are some points about this case I think worth dwelling upon. The original insertion of the internal rectus was seen on the globe, looking exactly as if just severed, yet eight years had passed since this had been done. Very likely a portion of the muscle was removed at the time it was first operated on, or lost by subsequent sloughing. It had become attached to Tenon's capsule and the conjunctiva. Notwithstanding the action of the superior and inferior recti in turning the globe inwards, the contraction of the external rectus turned it outward to the fullest extent. The superior and inferior recti acting together could only with effort bring the inner edge of the cornea up to the median line. The internal muscle, upon being again brought forward and attached to the globe, resumed its function; this we know it will do, provided fatty degeneration has not taken place. Whether this was the case could not be determined before the operation. The muscle when unused will, as we know, retain its color and anatomical condition for years.

Next to the success of the operation in relieving a positive deformity, the most interesting point to me in the case was, the appearance and persistency of the ulcer on the cornea. It reminded me especially of the sort of ulceration we have from a bruise or scratch of the cornea, or the ulcers of neuro-paralytic origin, e. g., after section of

the trigeminal nerve in the rabbit. Dr. Steffan, in the *Monatsblätter für Augenheilkunde*, 1867, p. 73, reports a case of sloughing of the cornea after operation for bringing forward the rectus. There was, however, paralysis of the oculo-motorius, and moreover the thread by which the globe was steadied may have irritated the cornea and caused suppuration. I used no thread as a guy to turn the globe; the conjunctivæ and lids were normal; not quite a half of the conjunctiva around the cornea was interfered with, and the light compressive bandage had been removed before signs of ulceration. Atropine alone was used to affect the ulcer. There was no injury done to the cornea before or after the operation. The patient, although suffering some pain, and worried by the operation, was otherwise in good physical condition, and in no way, at least, in that state which disposes to corneal ulcer.

Without some explanation, the treatment of this case might be open to criticism, since I deviated from the precise rules laid down by those who have practised it with most success. Prof. Graefe, for instance, advises against touching granulations with caustic. It must, however, be remembered that I did not have the ordinary end of the muscle or its tendon to deal with, but a frayed mass, which I was inclined to cut off at the time of the operation, and regretted afterwards not having so done. From this came the granulations which the caustic removed, to the relief of pain and discomfort. Again, I used no thread as a guy to steady the globe in its new position, contrary to express rules for this operation. The result proved that in my method of operating a guy was not necessary. It certainly is an advantage to avoid its use, from the difficulty of retaining it properly in place, and preventing its cutting through the muscle, more especially as we have to give ether, and may have the patient vomiting and tossing about some time after the operation. If a thread had been applied as a guy, the ulcer of the cornea might naturally have been attributed to it. Dr. Liebreich, who has lately succeeded in restoring confidence in the operations for squinting in Paris, reported, last September, at the Heidelberg meeting, a method of operating for bringing forward the muscle almost similar to the one I used in this case, his object being to avoid the loss of conjunctiva. It may also be asked, why did I leave the stitches so long. My reason was, that they produced no irritation, and not having used any guy I was of

course anxious to keep the globe rolled in all possible. The stitch in the ordinary operation for squint is frequently left to come away of itself, which it does without trouble. The method and means of limiting the amount of the operation I will not dwell upon here, and would only say that the operator gladly sees a convergence of 1-1½" afterwards. The convergence left in my case, if it does not disappear, as it generally does, is only too gladly changed by the patient for the divergence which directed the cornea at right angles to the visual axis of the other eye.

As soon as an eye deviates from its fellow so as to be thrown out of use, or its retinal impression suppressed by the brain, we know that its power of vision begins to decrease, and hence the importance of operating on squint in children early, in order to restore binocular vision and thereby preserve visual power. A careful examination of the refractive accommodation and vision in each eye is always the first step in deciding whether to operate, and how. Neglect of this and ignorance of its meaning and necessity have gradually caused great lack of confidence in all strabismus operations, and many eyes have in consequence, the past ten or fifteen years, been permanently injured from not having been operated on. Now, when an eye is brought back to act with its fellow, we know the power of vision will be restored, at any rate to a certain extent. Vision in my case had been reduced to ⅓rd of the normal; I do not look, therefore, to much improvement of sight in this eye. Even this amount assists, however, more than we should imagine in binocular vision, and is a great guard against injury approaching from that side. I have always been surprised to find this point unnoticed in the accounts of operations for squint; it is not discussed by Graefe. For the operator it is important that he should have the record of vision before operating, if only to prevent the patient suing him for having destroyed or injured the sight of the eye.

THE FIRST SUCCESSFUL CASE OF HIP-JOINT EXCISION IN PHILADELPHIA.—Dr. John H. Ashhurst, Jr., Philadelphia, relates in the *Pennsylvania Hospital Reports* the "first successful case of hip-joint excision which has ever occurred in Philadelphia." He adds a tabular view of 242 cases of hip-joint excisions, which is the most complete yet published.—*Medical Record*.

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Bibliographical Notices.

Annual Report of the Trustees and Superintendent of the State Lunatic Hospital at Harrisburg, Penn., 1868.

A SINGLE remark from the report of the Board of Trustees will show the limited provision yet made in the State of Pennsylvania for its insane population. "If five more hospitals," they say, "of the capacity of those already in active operation, were at this time ready for occupation, they would not more than meet the existing wants of the insane of this commonwealth; and very little accommodation would be found for the recent cases constantly occurring in all sections of the State."

The Superintendent, Dr. John Curwen, reports the whole number of patients under treatment during the year as 520. The number of admissions was 180—males 103, females 77. The number of discharges was 164—males 86, females 78, and the number remaining in the hospital Dec. 31, 1868, was 356—males 202, females 154. Of those discharged, 26 males and 21 females were restored; 14 males and 23 females were improved; 27 males and 28 females were stationary; and 19 males and 26 females died. The causes of death were—exhaustion of acute mania in 10, exhaustion of chronic mania in 10, disease of the lungs in 2, and strangulative disease of the brain, and epilepsy, one each.

Considerable repairs and improvements have been made in the buildings to perfect their internal arrangements and give more room for the accommodation of patients, making this, now, one of the largest and most convenient hospitals in the country.

The Doctor, in speaking of the erroneous impressions concerning the insane prevalent in the community at large, says:—"These impressions have been received from what they heard in relation to the treatment of the insane in former years, and from the ideas which still continue to prevail in relation to the nature and character of mental disorders. The prevalent impression seems to be that when an individual becomes insane all the faculties of the mind are so entirely disordered that they have no longer any knowledge of what is going on around them. Very few people have had an opportunity of seeing insane persons and of knowing how they may act; and ignorance of the true charac-

ter of the disorder can therefore hardly be wondered at. They have heard statements made by others of what they may have seen an insane person do or say, and these generally refer to cases of high excitement, whose language is of the most incoherent character, and their actions and conduct correspond; or to those whose perceptions are very much obscured, and who pay very little attention to what is passing around them, or have very little to say to any one. But between these two extremes there is every variety of deviation from the normal healthy condition of the intellectual and affective powers. In this variety consists the great difficulty of detecting what may be the healthy and what the unhealthy manifestations, and the consequent diversity of opinion as to the soundness and unsoundness of the mind of any given individual. A man may entertain delusions about himself or his family and his friends, which render him a perfect terror and torment to all with whom he may be on familiar terms, and yet in the presence of strangers and in the transaction of certain business matters he may be calm and more shrewd than usual, from the fact that the condition inducing the mental disorder may have sharpened his wits for the necessary business encounters with his fellow-men."

It is probable the *medical treatment* pursued in this hospital does not differ materially from that in other institutions of a similar character. The subject is not mentioned. The *diet* consists of plain, substantial, nutritious and well-cooked meals, served at regular hours; special provision being made for the sick. Out-door exercise is constant in suitable weather, and labor of some kind recommended.

The evenings are devoted to entertainments of a varied character, and on the Sabbath service is held regularly every morning, at which all who desire can be present. All are invited, but none are obliged to attend.

The disciplined aimed at in all the arrangements is similar to that of a well-regulated family.

C. K. B.

PREGNANCY AFTER OVIARTOMY.—Dr. T. Spencer Wells, in a note to the *Lancet*, says:—"Of more than twenty patients who had recovered after ovariectomy in my practice, and had subsequently become pregnant, I have not heard of one case in which there was any unusual suffering or difficulty during pregnancy or labor."

Medical and Surgical Journal.

BOSTON: THURSDAY, SEPTEMBER 2, 1869.

NOTES FROM FRENCH JOURNALS.

Ingestion of three Grammes of Croton Oil by a Child of six years, without serious Injury.—This drug, says the reporter of the case in the *Gazette des Hôpitaux*, though uncertain in its action, as shown by Troussseau and Pidoux, is yet capable of producing most dangerous symptoms and even death. The little patient in the present case was given by mistake three grammes of the oil in a cup of coffee. She took it in the morning before breakfast. She complained at the time of the detestable taste of the medicine, and of tingling in the fauces. A little while after, she had severe pain at the epigastrium, soon followed by violent and profuse vomiting, lasting for about three quarters of an hour. She then passed into a profound sleep of four hours' duration, at the end of which time she asked for food and was supplied with soup. She had no more pain, and only two loose but moderate dejections. The next day she was quite well, the only remaining effects of the drug being patches of vesicular eruption on those parts of the skin with which the ejected oil had come in contact.

[This reminds us of a case reported some years ago to the Boston Society for Medical Observation, by Dr. Slade, in which a very large dose of croton oil (we think ten drops) was accidentally administered to a patient, with no more effect than the ordinary dose usually produces. It was suggested, at the time, that there might possibly be in some persons such a thing as a sort of functional saturation of the system relatively to the drug, which would limit its effects.

In the French case, doubtless the free emesis removed a large portion of the oil. But, as the reporter suggests, it would be remarkable if a single drop had not remained; and in that case why was there not active purgation?—Ed.]

Bleeding in Pneumonia.—A clinical lecture with the above title, delivered by Dr. Peter at La Pitié, is given in the *Bulletin Général de Thérapeutique*. The lecturer begins his remarks by saying that a monstrous thing had taken place the day before—a patient had been bled in a medical ward! It was by a vindicating revolution of the wheel of events here below (*par un juste retour des choses d'ici bas*) that this occurred at Paris, where half a century ago blood was wont to be poured out with such prodigality, and where latterly bleeding had become a thing almost unknown.

The patient had pneumönia. He was 19 years old, pale and of lymphatic temperament—did not appear very sick the evening he entered the hospital. The next morning matters had entirely changed. The patient was very pale, but his pallor was that of asphyxia. His lips were purple, his face being livid, and his nostrils indicating by their action the dyspnœa of suffocation. He respired *sixty-eight times per minute*, while his pulse was from 128 to 132. Thus there was manifest want of accordance between the respiration and the cardiac action, the relation of one to the other being almost as 1 to 2 instead of 1 to 4, as is usual. He was in a state of ill-boding somnolence, from which questions addressed to him hardly roused him.

Bleeding was ordered. On returning to the bed-side after that had been done, the class saw him sleeping quietly. The movement of the *alae nasi* had ceased. The pulse was 108, the respiration 48. The latter had gone down, therefore, one third; and that in less than five minutes. The patient, on being interrogated, replied that he felt much better, and asked only to be let alone, so that he could sleep. In the morning, the oppression having partially returned, twenty dry cups were applied to the chest.

The following day—that is, two days after his entrance into the hospital—his pulse was 88, and this individual, as the lecturer triumphantly says, who yesterday was suffocating, to-day feels scarcely sick at all, and is almost ready to ask for his discharge.

The lecturer declares that it is through a defective interpretation of pathological

physiology that modern theory has denied the utility of bleeding in pneumonia, both for the lesion and the patient. He says it is admitted that by diminishing the mass of blood in circulation the power of absorption is increased, and that in consequence of this the removal of the exudation may be hastened. In this respect, therefore, it is held that bleeding may be useful in pneumonia. The hydraulic argument in favor of bleeding, he however thinks, is not a very happy one. For, admitting, he argues, with Valentin that the mass of blood in an adult man is about 12 kilogrammes, a bleeding of 500 grammes, diminishing the mass of the fluid in circulation *one twenty-fourth*, augments by only one twenty-fourth the power of absorption in the pulmonary vessels—a decidedly slender result. The morbid product in the lung, then, being diminished only one twenty-fourth, there is a material betterment of the patient of only one twenty-fourth. Now, M. P. demands of all those who have watched a patient with pneumonia after bleeding under certain circumstances, if this sorry amount of improvement is all that is gained. Instead of this fractional amelioration, necessarily tardy, that the hydraulic-physiological theory accords, there is a decided and immediately wrought condition of well-being. Pain has diminished or disappeared; dyspnœa has undergone the same modifications; the fever is lessened; the pulse is less rapid; the temperature lower. Such, he adds, was his patient, and such are all like him after bleeding. He thus seems to go beyond those who merely claim that bleeding is advisable for the suffocation which sometimes attends pneumonia.

M. P. now contends that instead of a hydraulic action, bleeding produces its effect by a dynamic influence through the nervous system; in the same way as tartar emetic acts, which does its work without the spoliation of any material from the body. He assumes that, in view of future reparation, we should not economize the blood too much; should not, because pneumonia is a disease of cycles, with a fixed course, contemplate its changes with Platonic coolness. For, he says, in order that the patient—the *pneumonist*—may “assist” at the cure of

his pulmonary lesion, it is absolutely necessary "that he should live as long as his lung;" and that he do not die at the first period of his famous "cyclic" malady.

[For ourselves, we are converts to the usefulness of bleeding, for the suffocation of pneumonia, in those rare cases where it occurs. We are also ready to be convinced that it may sometimes improve the general condition of the patient with pneumonia, even when the dyspnoea is not alarming. But, we have not been in the habit of seeing cases where it is called for.—Ed.]

Stimulants in Pneumonia.—Dr. Gros has had good success (*Union Médicale*) in treating pneumonia and broncho-pneumonia in infants of enfeebled or prostrated condition, with alcoholic stimulants. The tolerance, in the worst case, was noted to be diminished as the patient—an infant—improved.

Paracentesis Pericardii.—M. Roger reports (*Un. Méd.*) a case, with autopsy, of puncture of the pericardium in a girl of 12 years. In his remarks he says, there was failure of the usual remedies, and necessity for surgical intervention; and that the operation was harmless in itself, notwithstanding its great difficulties. The heart was displaced—lowered; but, on the other hand, its point was more easily found than usual, and consequently more easily avoided. Instead of inserting the trocar in the fifth intercostal space he introduced it into the sixth, at a point nearly equidistant from the mammary vessels and the apex of the heart; being guided also by the exceptionally visible pulsations. He withdrew 780 grammes of serum without getting all there was. The alleviation was immediate and marked, but the next day after the operation, concretions suddenly formed in the heart, especially on the right side; cyanosis and peripheral alidity showed arrest of the circulation; a clot obliterated the pulmonary artery in its right branch; and in consequence of all these lesions, together with hemorrhage at the summit of the right lung, death supervened by rapid asphyxia, in less than three hours.

Dr. R. asks, why did the coagula form in the cavities of the heart, when there was no endo-carditis, and when through the

abstraction of the serum by paracentesis, the organ, being no longer compressed, was more free in its movements? He answers that we must introduce into the chain of causation, here, the alterations of the blood common in the phlegmasia, and as for this case the *myocarditis* revealed at the autopsy. He exculpates the operation from all share in the fatal result, because the autopsy showed that the puncture was made at a suitable place, without injury to the substance of the heart, or to other organs, and without the development of traumatic pleurisy or pericarditis. In doing the operation, he adds, the possibility of myocarditis being present as a complication should be taken into account. He is opposed to delaying the operation to the last moment, and in favor of puncturing in season to avert the effects of long compression on the surrounding organs, and also to arrest the inflammatory process by the abstraction of one of the products of inflammation.

A Thesis presented to the "conours d' Agregation," reported in the *Gazette Hebdomadaire*, is by M. Lanceraux on *Diabetes Insipidus—Polyuria*. M. Lanceraux states that this affection is surrounded by a certain amount of obscurity for three reasons: that it is rare; that the analyses of the urine have often been incomplete or inaccurate; and because authors have sometimes set up ill founded or premature distinctions. Of the former he cites as an example, that between polydipsia and polyuria; of the premature distinctions he refers to that between simple hydruria (polyuria with very watery urine, and containing but little solid matter), anazoturia (diminution of the proportion of urea), and azoturia (exaggeration of urea). M. Lanceraux aims at more simplicity. With him, polyuria is a symptom developed in certain pathological conditions, as diabetes mellitus, diabetes insipidus, albuminuria, &c. It is only according to the characteristics of the urine, that we should define polyuria, or *diabetes insipidus*; and on this basis polyuria should be understood to be "a morbid state characterized by an exaggerated and not temporary emission of urine which is of feeble specific gravity, and devoid of sugar or albumen." Azoturia should be eliminated from the study of polyuria.

Pathological anatomy has not furnished us any precise instruction on this subject, unless it be that the kidney is not the source of the disorder. We are obliged to confine ourselves to the hypotheses, more or less plausible, of an alteration in the composition of the blood, of an augmentation of the pressure, or of an acceleration of the circulation in the kidney; all this being dependent on some lesion or other of the central nervous system which then acts through the intervention of paralyzed or excited vaso-motors (Roberts, Kien), or through that of the nerves of secretion situated between the artery and the renal vein (hypothesis of Wittich). However this may be, it must be acknowledged, says the reviewer, the question advances toward a solution; and it is in the nervous system that we must seek it. Clinical observation shows this. In 51 cases analyzed by M. Lanceraux, the pathogenic and etiological conditions are invariably seen to bear more or less directly on the nervous system. Here it is traumatic lesion of the head, there contusions, severe injuries on different parts of the body, excessive efforts, violent emotions; sometimes, again, it is hysteria, recent or former alcoholic excesses, sudden chilling of the surface; occasionally sunstroke, or acute disease. Finally, heredity is counted as an influence—a cause so powerful in all that relates to affections of the nervous system.

"*The Treatment of Diabetes Mellitus*" was the subject of M. Brouardel's thesis. We extract only a word or two from the analysis of it. The experience of Fick and Wiellencus in their ascent of the Faulhorn after a diet composed entirely of starchy matters—together with other experiments—lead to the belief that muscular action destroys a large proportion of sugar. An important case, observed by the reporter (a physician), in his own person, is cited by M. Brouardel. The diabetic, tired of following out assiduously and without success, the most rigid plans of treatment, such as a diet exclusively nitrogenous, *eau de Vichy*, iodide of potassium, arsenic, &c., got well in six months while using regular and vigorous exercise in the open air. The author, M. B., draws the conclusion that there is no

medication which is applicable indiscriminately to all patients with diabetes. Certain of the means proposed, he asserts, have effected authentic cures. But the first thing to consider is the multiplicity of the causes of diabetes. The treatment should, when practicable, be addressed to the cause, which, however, often escapes discovery.

DR. GROUX BEFORE THE AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE. TELEGRAPHIC AUSCULTATION.—This Association has recently been in session at Salem, Massachusetts. At one of the meetings Dr. J. Baxter Upham, of this city, introduced Dr. Groux, whose remarkable malformation is well known to the medical public. We take the following account of the proceedings relative to Dr. Groux and others from the *Boston Daily Advertiser*:—

Dr. Groux was born in January, 1831. At the age of three years he was subjected to a private examination by the physicians of his native city to determine whether any surgical operation should be recommended. He attended school regularly during his youth, joining in all the sports of his play-fellows. At the age of fifteen he went to London, where he was visited by the principal physicians. On his return to Hamburg he was placed in a drug store, but he was soon attacked with pleurisy in his right side, which left him very feeble. In 1851 he began the tour of Europe, where his case excited universal attention, and in 1856 he was retained for some time in Russia, against his will, by government authority. In 1858 he visited America, returning in 1859 to attend medical lectures in Göttingen, where he received the degree of M.D. in 1862. After walking the hospitals of London, and receiving numerous diplomas, he removed to Williamsburg, N. Y., where he has since remained, in successful practice.

Several cases of somewhat similar malformation have been reported, but the present is the only instance in which the absence of the sternum was congenital and complete, and the patient so intelligent as to be able and desirous to make his position as valuable as possible to science.

Dr. Upham described the anatomical position, appearance and action of the heart, stating that our knowledge of its position has been improved by an examination of

Dr. Groux, the relaxed muscles of the corpee causing it to fall somewhat from the place that it naturally holds in life. The sounds of pulsation were fully described, as well as the intervals between the successive portions of the pulsations in the auricle, the ventricle and the aorta. Those intervals have been measured in thousandths of a second, by the chronograph, which was invented by the late Prof. Bond, of Harvard University.

Dr. Groux then proceeded to try some experiments on himself, removing his coat and exposing his breast, so that it could be readily seen that there was nothing but muscular integuments between the skin and heart. He exhibited photographs and drawings to explain the peculiarities of his malformation, and by placing feathers on various portions of his breast he made each beat of his pulse plainly visible to the entire audience. Galvanic wires, connected with bells, were then substituted for the feathers, and the pulsations were made audible as well as visible.

Two physicians were invited from the audience, one of whom applied a stethoscope to the breast, while the other held his finger on the pulse of the right hand. Dr. Groux then took a deep inspiration, and compressing his lungs, the motions of the heart were made to cease for several seconds. By slow inspiration the flow of blood was partially arrested, and the auricles filled with blood, so as to appear swollen. India-rubber tubes, with glass extremities, filled with different colored fluids, were also applied in such a manner as to show the successive portions of each pulsation.

After explaining the improvements in the diagnosis of aneurisms which the case had suggested, Dr. Upham proceeded, with the aid of the telegraph and magnesium light, to render audible and visible the pulsations of patients in the City Hospital in Boston, Mr. Farmer having charge of the telegraph instruments in the lecture-room, Mr. Stearns at the City Hospital, and Dr. Knight, assisted by the internes of the Hospital, taking the medical direction. The Franklin Telegraph Company placed their entire line between Salem and New York at the disposal of the Association, and every pulse-click of the magnet was heard simultaneously at every station on the entire line. Dr. Flint, in New York, and Dr. Ives, in New Haven, will probably report the receipt of the information at those stations.

One purpose of Dr. Upham in exhibiting these experiments was to show the truth of

the suggestions he made some years since in regard to the retardation and weakening of the pulse through the influence of aneurismal tumors under certain circumstances. Normal and abnormal pulsations of the heart were told off by telegraphic communication from the City Hospital in Boston to the audience hall in Salem, some fifteen miles distant. So marked were the manifestations as to enable those witnessing them to judge correctly of the diseases of the patients. Dr. Upham does not claim any great practical results from these attempts; but only that they are suggestive of what may possibly be done in that direction in the future. It occurs to us as within the range of possibility that such experiments may be put to use in the public auditorium of the clinical lecturer.

MODERN HOMŒOPATHY.—From the *London Monthly Homœopathic Review* for June, 1868, we learn that Lord Ebury gave vent to a feeling of regret that the report of the London Homœopathic Hospital did not contain evidence of a greater development of the objects of the institution. The number of patients was not very large, and the clinical lectures had been given up, "owing to the attendance being so scanty as greatly to discourage the lecturers." In the London Homœopathic Hospital, in which the cases are not of so serious a character as one is accustomed to see under treatment in hospital, black wash is applied to syphilitic sores, and $\frac{1}{2}$ gr. doses of mercury given internally. Cases of glandular enlargement in the neck were treated with tincture of iodine painted on externally. For cases of continued sleeplessness 1.48 [?] of a grain of acetate of morphia was given every fifteen minutes. The hospital physicians repudiated, one and all, the fallacies and absurdities of Hahnemann about infinitesimal doses and dilutions.—*Detroit Review of Medicine and Pharmacy.*

SUPPOSED AMPUTATION OF THE FINGER OF A CHILD IN UTERO BY THE FUNIS. By EDWARD CHEATLE, L.R.C.P. Edin., Revesby, Boston, Eng.—On June 8th, I attended Mrs. R. in her third labor. The labor was natural, with the exception of the funis firmly encircling the neck and left arm, the pressure being so great that I had to resort to artificial respiration for some minutes, which, after a time, was successful. While I was

using means for resuscitation, I noticed the absence of the second finger of the left hand; and, on a more careful examination, I found a distinct cicatrix at the end of the metacarpal bone, presenting the appearance as if amputation had been performed at the metacarpo-phalangeal articulation, the same wide space being left as would occur when the head of the metacarpal bone is not removed. The idea occurred to me that it might have been amputated by the funis, as that encircled both arm and neck.—*British Medical Journal*.

THE PONS VAROLII THE NERVOUS CENTRE OF GENERAL CONVULSIONS.—H. Nothnagel (*Virchow's Archives*) arrives at the following conclusions in regard to the nervous centre of general convulsions, which are derived from actual experiments. The centre of general convulsions is situated in the substance of the pons. Its lower boundary is corresponding to a section at the height of the inferior border of the pons. The faculty to perform the function of a centre of spasms is to be denied to the substance of the medulla oblongata.

Finally, he endeavors to prove that the spasms are produced by way of reflex. In some instances the section of the medulla oblongata had been made below the pons, the animals remaining absolutely quiet. Again: the convulsions occurred if the section had left a portion of the pons connected with the medulla oblongata, showing the centre of action to be situated outside of the medulla.

At last the anatomical condition of the region of spasms is confirmatory to the view of reflex action. The region nearly corresponds to the situation of the gray nuclei and root-fibres of the sensitive cranial nerves. While the nuclei and roots of the motor cranial nerves are near the raphe, those of the sensitive nerves are more lateral. The root-fibres of the portio major trigemini in particular, descend, according to Schroeder van der Kolk, through the whole length of the medulla. This anatomical condition, it must be conceded, is no direct proof of a reflex action, but it renders it admissible and plausible.

From all this it seems that the convulsions following the injury of a defined region on the floor of the fourth ventricle are to be explained as spasms induced by reflex action.—*Dub. Med. Press & Circular*.

CRIMINAL ABORTION NOT CONFINED TO THE UNITED STATES.—In the London *Medical*

Times and Gazette we read that "a miscreant named Fowkes, described as a newspaper agent, has been sentenced, at the Warwick assizes, to ten years' penal servitude for the felony of attempting to produce an abortion on the person of a young woman named Susannah Bromfield. The seducer of the girl, one Bailey, who took her to Fowkes for the purpose, has been sentenced to five years' imprisonment. The counsel for the defence tried to make the girl an accomplice or consenting party, and urged that it was necessary that corroborative evidence should be produced before a conviction could take place. The only corroboration that could be offered was the testimony of the police, who found medicines, books and instruments on Fowkes's premises, and who proved that when Fowkes was apprehended he asked, in Bailey's presence, whether, if Bailey married the girl, the prosecution would be stopped. We are glad that the judge, in summing up, completely disposed of this plea—first, by directing that, to make the girl an accomplice, she must have known that an instrument was to be used on the first occasion of her going to Fowkes's shop; and that, even if the jury considered her an accomplice, the evidence of the police, and the admission implied in Fowkes's question to the police, were sufficient to support her story. We are glad that the judge (Mr. Justice Brett) took this decided line. In too many of these cases some legal quibble has produced an acquittal, when the evidence of guilt to ordinary persons was quite clear. If the judges show themselves determined to uproot, in spite of legal difficulties, what we fear is an increasing crime, they will deserve the thanks of the community."

CIRCUMCISION.—From an article on this subject by A. B. Arnold, M.D., Baltimore, Md., in the *New York Medical Journal*, we make the following extracts:—

* * * Herodotus alludes to the customs of circumcision among the Egyptians, the Colchicans, the Ethiopians, the Phœnicians, and certain tribes of Syria. On the authority of Clemens of Alexandria, it is reported that Pythagoras had to submit to circumcision before he was allowed to be initiated into the mysteries of the Egyptian priesthood. It is remarkable that while the Mohammedans practise circumcision as a religious observance, no command is contained in the Koran to make this rite obligatory. This evidently shows that, among the Arabians, with whom the Moslem reli-

gion originated, the usage of amputating the foreskin had acquired a sanction, which not even a radical change of religion could weaken in the least. The Bible informs us that Abraham was circumcised, in obedience to divine command, and yet it is singular that Scripture is silent in regard to the question, whether the patriarch, who was then ninety-nine years of age, circumcised himself, or was circumcised by some other person. The context in which this biblical passage occurs, and argument from the verbal construction of the language employed, suggest the inference, that the practice of circumcision in Abraham's time was already an established custom. * * *

The query arises, however, why the external genital organ of the male was selected for the mark of the Abrahamic covenant? Some of the learned men have found no difficulty in solving also this problem. The ancient Egyptians and the Syrian tribes inhabiting portions of Asia Minor, symbolized the creative or generative power of the Deity by crude images of the pudenda. Herodotus tells us that, when he travelled through Syria, he saw a number of such ill-shaped things (phalli) erected on hills, and in groves. The foreskin was imagined to be an obstruction to the functional activity of the male organ, and was therefore removed as an inappropriate appendage. This seems to be indicated by the Hebrew word *orel* (prepuce), which is used in the sense of impeding or checking. * * *

Among a large number of rules contained in the Talmud respecting circumcision, the following are noteworthy:—If a father lost two boys by circumcision, he was absolved from having the succeeding full brothers circumcised. Sickly and feeble children, or those whose skin is unusually red, or yellow, are exempt from the operation. The advice of a physician is necessary whether a child is able to undergo the operation at the stated time. * * *

The operation of circumcision is a very simple affair, and, if properly performed, ought to be finished in less than a minute's time. In the hands of non-professional persons, the operation looks, sometimes, formidable enough, owing in some measure to the accompanying ceremonial, but more especially to the remnants of the vicious surgery of a past age. The most objectionable feature is the squirting of wine on the fresh wound, followed by the sucking of blood with the mouth. This procedure, technically called *mezizah*, has recently found many and influential opponents within Jewish communities, and has even been

interdicted by Rabbins of high authority. I have never imitated this practice, which, I am happy to say, meets the approval of American Israelites of this city, and received the sanction of the late pious and learned Rabbi, Abraham Rice, who was then at the head of one of the most numerous and orthodox Jewish congregations of this country.

The apparatus used consists of a two-edged knife of considerable size, rounded off at the point, where it has a dull edge. Perhaps a pair of scissors would be preferable, but this innovation has not yet been attempted by any one. I use a small scalpel, as the convex blade offers some advantage. A guard, or shield, composed of a plate of silver or ivory, having a slit in the centre which runs longitudinally for compressing the prepuce, is now in general use. The operator keeps the nails of both his thumbs sharply pointed. A glass of water and a narrow strip of lint complete the preparation. The person who holds the child sits on a chair, his feet resting on a low stool, and approximates his knees. A small pillow is placed on his lap, on which the child is laid on the back, with the head directed toward the left side of the assistant, who carries his right hand under the knees of the child to steady them by his thumb, his left hand passes over the left shoulder of the child, by which he keeps the trunk in position. The operator stands at the feet of the child, and seizes the prepuce between his left thumb and index finger, and draws it upward. He then slides the guard from above downward, and from right to left, over the prepuce, which is constricted between the fingers and the glans. The knife is now held outside of the guard, and with one cut, or perhaps two, the foreskin is severed. Immediately the wounded cutis of the penis retracts behind the fossa, and occasionally to such an extent, that the penis acquires the appearance of having been completely skinned. Only a small portion of the inner lamella of the prepuce is usually cut away, and, being of a less elastic nature, is found to cover a part of the glans. Sometimes it remains intact, and may still cover the entire glans, and even project beyond it. If this be the case, it ought to be removed by a short sweep of the knife, as it would otherwise dangle about in shreds after the parts have healed. Generally, however, the glans is exposed sufficiently to allow of the next stage of the operation. This consists of the laceration of the inner fold of the prepuce, and is done for the purpose of divesting the

glans of the remaining portion of the foreskin. After the guard has dropped, or has been removed, the nail of the left thumb is introduced between the inner lamella of the prepuce and the glans, and held tightly with the aid of the left index finger, and is then gently drawn upward. The nail of the right thumb is introduced in a similar manner, but opposite and nearly in contact with the other nail, so that, in conjunction with the right index finger, the free margin of the circumcised skin is torn on its superior side to near the corona glandis. Very little blood escapes, and nothing further is required to be done than to wrap a narrow strip of lint around the wound, which is kept *in situ* by the agglutination of the blood, and protected from friction by pinning the diaper in the usual manner. The wound heals rapidly, although a slight tumefaction of the parts is frequently observed on the next day, when the dressing may be safely removed and replaced by a thick layer of the common infant powder. * * *

Dr. Arnold goes on to speak of certain deviations from the normal type of the prepuce for which the operator should be prepared. From among these we quote the following:—

A kind of malformation is sometimes met with in male infants, which causes considerable anxiety to the parents, and seems to forbid the operation of circumcision. In these instances, the scrotum and the enclosed testicles are perfect and in proper position, but the place of the penis is occupied by a small globular tumor, resembling a nipple, which proves to be the point of the prepuce. On closer examination, the finger will feel the body of the penis imprisoned behind the little pouch of foreskin, and ready to spring forward when released from its confinement by circumcision. * * *

PARACENTESIS PERICARDII.—Dr. Clifford Allbutt reports a case in which this operation was performed with markedly good effect. In a former case, which he had under his care two years and a half since, the success was complete and final; in the present instance, the operation only acted as a palliative. The patient was a weakly girl, aged 27, in whom pericarditis with extensive effusion had come on somewhat insidiously, and was causing the greatest distress; it was thought she could not survive the night. However, some stimulants having been administered, the force of the pulse was somewhat increased. Friction sounds were present, but there was such

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unequivocal evidence, from other physical signs, that there was not merely lymph, but a large quantity of serous effusion, that Dr. Allbutt requested Mr. Teale to operate. A fine exploring trocar was inserted in the fifth interspace, about an inch from the left border of the sternum; the point was thrust upwards and inwards till it touched the heart. The point was now sheathed, and the canula was driven well home, till the heart jerked it to and fro. The canula was then partly withdrawn, and serum began to flow. The tube now slipped a little and the trocar had to be re-inserted, to carry it home. The straw-colored serum now flowed again. About five ounces of fluid were drawn off, and the patient experienced great temporary relief. The case had, however, too far gone; there was extensive oedema of the lungs, and on the following day the patient was as bad as ever, and there was so much distress that the puncture had to be repeated. It again gave great relief, though not so great as the first operation had caused, but the patient sank a few hours later from bronchitis and pulmonary oedema. Dr. Allbutt remarks that tapping the pericardium is really a very simple operation; and that there is no reason to fear that a slight accidental wound of the heart would do any harm. On the present occasion a little air accidentally entered the pericardial sac. Dr. Allbutt will in future cases guard against this by connecting the canula with an India-rubber tube whose extremity dips under water. He points to the ready emptying of the sac by the expansion of the lung, in this case, as a refutation of Oppolzer's objection to the operation—that the sac, having no elasticity, and being placed in the unyielding chest-cavity, cannot be properly emptied, or if emptied will re-fill.—*Lancet*.

INTESTINAL OBSTRUCTION CURED BY ENTEROTOMY.—Cases of this kind are so rare that it may be well to mention one which was brought before the Société de Chirurgie by M. L. Thomas, of Tours. The operation was performed, as usual, in the right flank, and an enormous mass of feces escaped from the distended cæcum, which had been sewed to the abdominal wall. In a few days the natural passage through the intestine was reestablished, and everything went excellently well up to the twenty-fourth day, when a fresh accumulation of feces occurred, in the iliac flexure. However, this was removed by the persevering use of enemas with a long tube; and the natural

action of the bowels becoming perfectly re-established the artificial opening nearly closed of itself. The cure appears quite permanent.—*Jour. de Méd. et de Chirurgie Pratiques.*

SUSCEPTIBILITY OF THE SKIN OF NEURALGIC PATIENTS TO BLISTERS.—Dr. T. King Chambers has addressed an interesting query to us, which we are at present unable to answer satisfactorily, and we invite our readers to assist us with the results of any careful observations which they may have made on the subject. The question is, does neuralgia generally diminish the susceptibility of the skin of the painful parts to the vesicating action of cantharides? Dr. Chambers has observed a certain class of neuralgic cases—those, namely, which are associated with mental depression and hypochondriasis—in which this deficient power of reaction in the skin does appear to exist, and he inquires whether the fact is true of other forms of neuralgia. So far, the evidence which we have been able to obtain on this point is conflicting, but we invite further communications from those of our readers who have had large experience of the treatment of neuralgic affections.—*Practitioner.*

SERIOUS CHARGE AGAINST A MEDICAL PRACTITIONER.—We quote from an Irish paper the following report. It furnishes another instance of the dangers to which medical practitioners are exposed in the honorable discharge of their duties. Dr. Wm. Bennett Forde was placed at the bar charged with a felonious assault. * * * Mr. James Green, Q.C., stated the case for the Crown. The prisoner was a medical practitioner at Queenstown, and the prosecutrix, Ellen Kearns, was a girl of 13 years of age, in the employment of a confectioner named Hammond. The girl complained of being ill, and her mistress sent for Dr. Forde, who came and took her back to his shop for the purpose of giving her a remedy. It was alleged that in his shop he committed the offence. He afterwards called at the house, and on each occasion the girl fainted on seeing him, and got an hysterical fit. When finally on examination, she stated what had taken place. The girl, Ellen Kearns, was produced and examined by Mr. Waters, Q.C. She proceeded to detail the facts at length, but in a manner so different from her informations, that his Lordship stopped the case and retired for ten minutes to consider it. On his return into

court, Mr. Green, Q.C., said that, upon consultation with his colleagues, he thought it but just to withdraw from the prosecution. His Lordship directed an acquittal, and said that the story was evidently the offspring of the child's diseased imagination, and the prisoner left court without a stain on his character. Fortunately for the honor of the profession, these charges when investigated are generally found to be false, but this trial, as well as many others which have taken place, inculcate the necessity of extreme caution on the part of our brethren. Consultations of a delicate kind should never take place except in the presence of a third party. The reputation of a medical practitioner is like that of the wife of Cæsar—it must be "above suspicion."—*Medical Times and Gazette.*

DETROIT, JUNE 30, 1869.

MY DEAR DOCTOR,—Agreeably to the following resolution of the Michigan State Medical Society, dated June 10th, 1869, viz. :—

"Resolved, That Dr. Henry F. Lyster, of Detroit, be appointed a committee of one to prepare a report on the operation of excision of the hip-joint, with especial reference to the statistical results, and that he be empowered to have blanks printed at the expense of the Society, to be sent to all surgeons who have recently performed the operation, in order that this report may embrace information that cannot be found in books and journals."

I transmit to you the accompanying blank, requesting you to report all cases of excision of the hip performed by you for morbus coxarius.

The committee will feel greatly indebted for a detailed description of each case operated upon, together with your opinion upon the value and advisability of the operation, and the stage, circumstances and conditions, &c. &c., in which it may be performed to the best advantage.

Full credit will be given in the published Transactions of the Society for any report you may see fit to make.

Very sincerely yours,
HENRY F. LYSER, M.D., *Committee.*

The above circular is presumably addressed to every member of the medical profession; and we presume that every one who has had a case or cases of the kind alluded to, and who may see this, will reply to the following questions relative to such. We embody the points on which informa-

tion is sought from the blank table accompanying the circular sent us:—

No. of cases; sex; age; side of body; causes, and duration of disease; condition at time of operation; operation; progress of case and result; utility of limb; causes of death, and duration of life in fatal cases; date and place of operation; operator and assistants; remarks.

INQUEST.—The jury summoned by Coroner Thaxter to investigate the circumstances connected with the death of Thomas Norton, previously mentioned in the papers, have returned the following verdict:—

"That Thomas Norton came to his death about 2½ o'clock, A.M., August 20th, 1869, from the effects of a large and poisonous dose of laudanum administered to him under the supposition that it was tincture of rhubarb. And the jury further find that the fatal dose administered to deceased was purchased as and for tincture of rhubarb, at the apothecary store of David J. Sewell, No. 1257 Washington Street, and was dispensed by William J. Saville, employed there, who had been positively instructed by the proprietor not to sell or put up medicines, and who did sell in this instance two ounces of laudanum for the two ounces of tincture of rhubarb which was called for."—*Boston Daily Journal*.

MANSLAUGHTER.—William J. Saville, the clerk in David J. Sewell's drug store, who sold tincture of opium to Mr. Chas. S. Patten, for tincture of rhubarb, was arraigned before the Municipal Court in Boston, Aug. 30th, on the charge of manslaughter, in causing the death of Mr. Thomas Norton, of No. 5 Springer Court. The government called the same witnesses as appeared before Coroner Thaxter at the inquest on the 24th inst., and the same testimony was elicited, which was to the effect that Mr. Norton being quite unwell—troubled with the bowel complaint—his friend and employer, Mr. Charles S. Patten, went to the drug store of Mr. Sewell, at 1257 Washington Street, to procure some tincture of rhubarb. That he bought what he supposed to be rhubarb of the young clerk, Saville, took the preparation to the house of Mr. Norton, gave the same to his wife, who administered it as directed by the druggist, the same being one-half of a two ounce vial. The medicine proved to be tincture of opium, and the dose, being seven or eight drachms, caused the death of Mr. Norton in a few hours. After hearing all the evidence in the case, the

Court required the defendant to find sureties in \$1000 to await the action of the Grand Jury.—*Boston Daily Herald*.

THE SUPPOSED POISONING BY A PHYSICIAN.—**THE DOCTOR EXONERATED.**—An inquest was held yesterday by Coroner Keenan in the case of Mrs. Rosina Klett, of No. 424 East Ninth Street, whose death was supposed to have resulted from certain powders administered by Dr. Wm. Plumer, of No. 210 Avenue A.

Chas. Klett, the husband, deposed to the facts in the case as stated.

Wm. Plumer, of 210 Avenue A, deposed as follows:—*I am a homœopathic physician, and was called in to attend Mrs. Klett on the 17th inst.; she was then in a very feeble state, and had violent afterpains; she complained of pain in the stomach, and continued in that condition until the time of her death; her husband asked me for some powders to cause sleep; on Tuesday he came to my house and I gave him four powders, each containing one-eighth of a grain of acetate of morphine; I weighed it myself; I ordered one powder first, and if she did not sleep to give her another powder after waiting a few hours; I gave these powders to produce sleep; deceased was in a fever and had cramps in the stomach; I doubt now whether she had peritonitis or not; I graduated in Germany.*

Drs. Wooster, Beach, Finnell, Clark and others, who had made the autopsy on the remains, deposed that they found inflammation of the womb and surrounding parts; in their opinion death was caused by *pyæmia* from an abscess; her condition should have been made out by an intelligent physician; if she had severe pains morphine should have been given; if not, that medicine would have been improper; an eighth of a grain of morphine is not a homœopathic dose.

This closed the testimony in the case, and the jury rendered a verdict of "death from *pyæmia*."—*New York Times*.

ACKNOWLEDGMENT.—"Communicated for the *Boston Medical and Surgical Journal*."—We received through the mail a few days ago, from Dr. Amos Sawyer, of Hillsboro', Illinois, a novel contribution in the shape of a glow worm. The donor, to whom we express our thanks, sent it, he says, thinking it might be a curiosity; and it was. We suspect, however, that Dr. Sawyer kindly intended to add light to our editorial lucubrations!

Medical Miscellany.

CIRCULAR.—The medical profession, and scholars generally, are aware of the ephemeral form in which most of the early American contributions to the literature of medicine were given to the world, and, indeed, in which many of the more recent are being published. This condition of much of our professional literature is deeply regretted by all, and particularly by those whose taste and research lead them to refer to this class of works, when the fact is made apparent that whole editions of tracts and books have entirely perished through neglect. With a view to provide against such a contingency, and preserve, for the benefit of the profession, in some accessible and central locality, copies of all home medical publications, the American Medical Association, at its annual meeting in May last, resolved to establish at Washington, D.C., a Library or Repository of American medical works, to which it is believed all the current medical literature of our country will be cheerfully, promptly and constantly contributed.

It is designed that this repository shall contain copies of every contribution by American physicians to the literature and science of medicine, from the earliest settlement of our country, no matter how or where published, including all the books, pamphlets, journals, and even unpublished manuscripts, that can be collected.

An appeal for contributions to this library is now made, personally and distinctly, to each and every American physician, medical publisher, and editor, to deposit copies of their works in this repository, where they will be carefully kept for reference and catalogued with the name of the donor.

We, the undersigned, members of the American Medical Association, having been selected to carry into effect, as far as practicable, the resolution of the Association to establish a Library, have now completed all the necessary arrangements for the reception and preservation of those books which may be sent to our care. Contributions of the class of works mentioned, are therefore respectfully and earnestly solicited from every source. Packages may be sent by mail or by Adams's express, to either of us, which will be promptly acknowledged on reception, and a record of titles kept. The library-mark of the Association will be pasted on the inside of the cover of each Volume, which will contain also the name of the donor.

We remain, respectfully,

ROBERT REYBURN, M.D.,

Librarian.

JOSEPH M. TONER, M.D.,

Library Committee.

WASHINGTON, D. C., Aug. 16, 1869.

Letters of inquiry, we are informed, may be addressed to Dr. Reyburn, at 120 F Street, or to Dr. Toner, 45 La. Avenue.

By accident, it was not stated in the JOURNAL of last week that the review of Dr. Bigelow's book was written from advance sheets. Booksellers will probably be supplied with the book within a week.

A CIRCULAR from the Southwestern Book and Publishing Co. announces "the discontinuance of the publication of the *St. Louis Medical Reporter* for the present," and states that unless new arrangements are soon made whereby the work can be furnished to subscribers without incurring so great a loss as the past has proved, the subscription money for the unexpired time paid for will be refunded.

MEDICAL DIARY OF THE WEEK.

MONDAY, 9 A.M., Massachusetts General Hospital, Med. Clinic. 9 A.M., City Hospital, Ophthalmic Clinic.
TUESDAY, 9 A.M., City Hospital, Medical Clinic, 10 A.M., Surgical Lecture. 9 to 11 A.M., Boston Dispensary. 9-11 A.M., Massachusetts Eye and Ear Infirmary.
WEDNESDAY, 10 A.M., Massachusetts General Hospital, Surgical Visit. 11 A.M., OPERATIONS.
THURSDAY, 9 A.M., Massachusetts General Hospital, Medical Clinic. 10 A.M., Surgical Lecture.

To CORRESPONDENTS.—Communications accepted:—On the Treatment of Typhoid Fever by the Reconstituents—Pau as a Resort for Invalids.

MASSACHUSETTS MEDICAL SOCIETY.—We are requested to correct two errors of the press in the last issue of the *Medical Communications* of the Society. On page 114, in the list of Councillors for Berkshire County, the name of Dr. Louis Miller, of Stockbridge, should have been printed instead of Dr. J. Leland Miller, of Pittsfield; and on page 118, Dr. Andrew M. Smith, of Williamstown, should have been named as President of the Berkshire District Society, and not Dr. Abner N. Smith, of Pittsfield.

BOOKS AND PAMPHLETS RECEIVED.—The Jurisprudence of Medicine in its relations to the Law of Contracts, Torts and Evidence, &c. By John Ordronaux, LL.B., M.D. Philadelphia: T. & J. W. Johnson & Co. —A Text-Book of Practical Medicine, with particular reference to Physiology and Pathological Anatomy. By Dr. Felix von Niemeyer, Prof. in the University of Tübingen. Translated by George D. Humphreys, M.D., and Charles E. Hackley, M.D., New York. Vols. I. & II. From D. Appleton & Co., New York.—Electricity in its Relations to Practical Medicine. By Dr. Moritz Meyer. Translated, with Notes and Additions, by William A. Hammond, M.D., New York. From D. Appleton & Co., New York.—Carbolic Acid: Its Action and Uses. By Charles F. J. Lohblach, M.D., of Newark, N. J.—Puerperal Eclampsia. By C. C. F. Gay, M.D.—Feticide, or Criminal Abortion; a Lecture Introductory to the Course on Obstetrics and Diseases of Women and Children, University of Pennsylvania, Session 1869-40. New Edition. By Hugh L. Hodge, M.D.—Transactions of the Indiana State Medical Society at its Nineteenth Annual Session, held at Indianapolis, May 19 and 20, 1869.—The Illustrated Annual of Phrenology and Physiology for 1870. By S. R. Wells, Editor of the Phrenological Journal and Life Illustrated.

DEATHS IN BOSTON for the week ending August 28, 1869. Males, 59—Females, 41.—Abscess, 1—accident, 4—disease of the bladder, 2—inflammation of the bowels, 1—disease of the brain, 3—inflammation of the brain, 3—cancer, 3—cholera infantum, 19—cholera morbus, 2—consumption, 13—convulsions, 5—debility, 2—diarrhoea, 1—diphtheria, 1—dropsy of the brain, 4—drowned, 2—dysentery, 3—erysipelas, 1—scarlet fever, 2—typhoid fever, 2—disease of the heart, 4—infantile disease, 2—disease of the liver, 1—congestion of the lungs, 1—inflammation of the lungs, 1—marasmus, 3—menstrual, 1—old age, 1—paralysis, 1—premature birth, 1—teething, 1—ulcers, 1—unknown, 7—whooping cough, 4.
Under 5 years of age, 52—between 5 and 20 years, 5—between 20 and 40 years, 21—between 40 and 60 years, 10—above 60 years, 15. Born in the United States, 67—Ireland, 23—other places, 13.